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IDENTIFYING AND ADDRESSING BURNOUT

SPEAKERS

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OBJECTIVES

- Identify opportunities for building and enhancing resilience to occupational stress.
- Recognize the symptoms of burnout to differentiate them from depression and stress disorders.
- Discuss issues that impact healthcare protocols and practices.

BURNOUT- A ROADMAP

- What constitutes burnout?
- At what stage of career does burnout start?
- When is it no longer burnout, but stress, depression, or Post-Traumatic Stress Disorder?
- Do we understand neurobiological and physiological underpinnings of the burnout syndrome?
- Are there available remedies on personal versus organizational levels?

Burnout- Definition

- A syndrome
  - Across a spectrum of severity
  - Herbert Freudenberger,"burn-out syndrome", 1974
- Identified at all levels of training and practice
- In all industrialized countries
- Emotional, mental, and physical exhaustion caused by excessive and prolonged stress
- A modern disease

Burnout- Definition

- Triad consisting of:
  - Emotional exhaustion
  - Depersonalization
  - Reduced sense of personal accomplishment.

  Maslach C, Jackson S (1981) The measurement of experienced burnout. J Occup Behav 2:99–113; Maslach C, Schaufeli WB, Leiter MP (2001) Job burnout. Annu Rev Psychol 52:397–422)

  - Very prevalent in jobs involving *human service:* social workers, nurses, teachers, lawyers, physicians, police officers
    - "the helping professions"

ELEMENTS OF BURNOUT

Emotional exhaustion

Depersonalization

Reduced sense of personal accomplishment

ALTERNATE TERMINOLOGY, AND BOUNDARIES, UNCLEAR

- Reduced work-related psychological health
- Stress
  - Mismatched expectations?
  - Bored, overloaded, or unappreciated
- Absence work-life balance (gender effect?)
- Depression?
- Responder apathy syndrome
- Acute stress disorder or post-traumatic stress disorder (PTSD)?

EXPECTATIONS VS REALITY

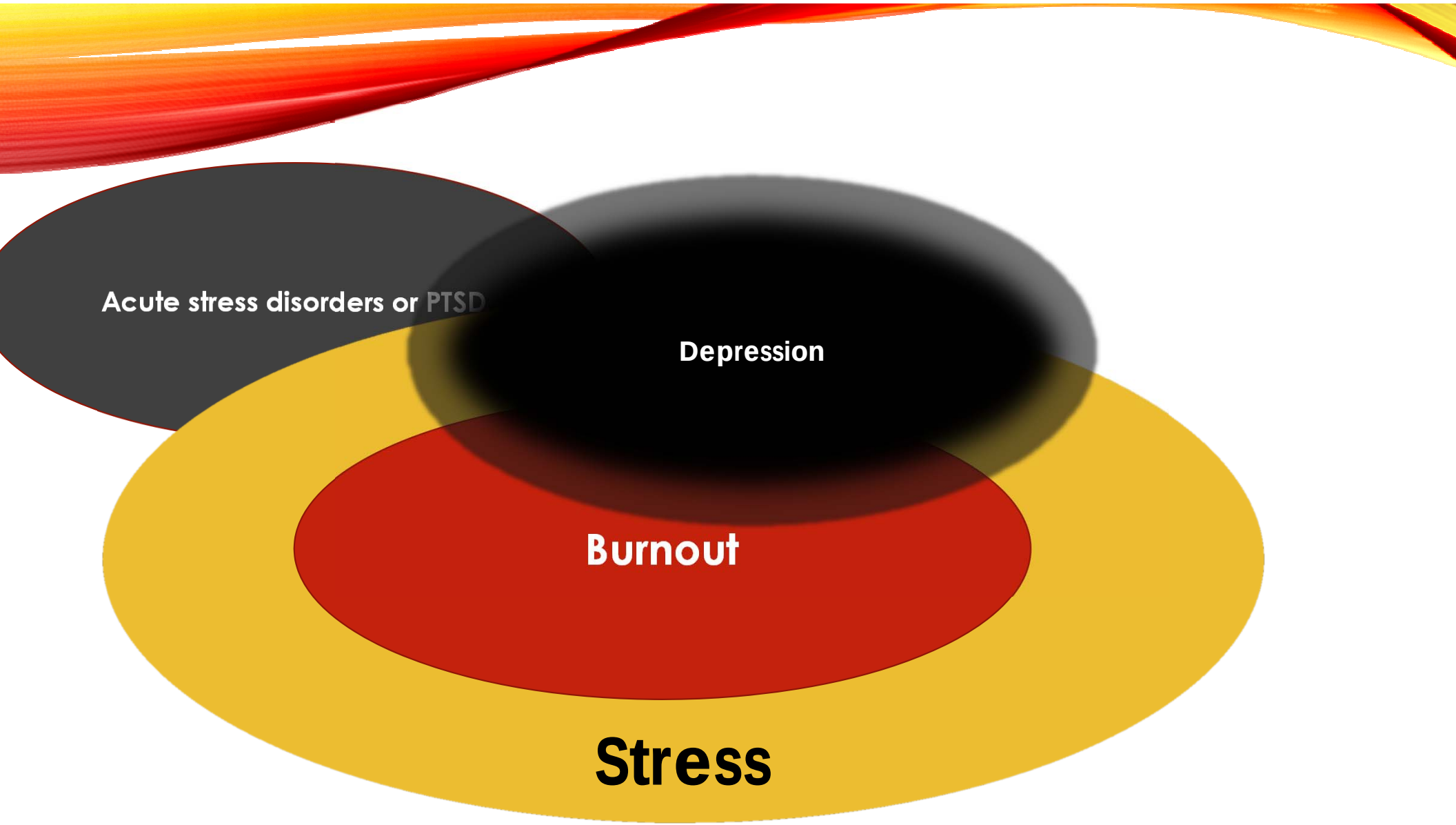
- Up to 70% of physicians report feeling burned out
- 50% of physicians in practice would NOT recommend medicine as a career to younger individuals
- The percentage of physician who own their practice has declined
- The average osteopathic (D.O.) medical school graduate has $205,675 in debt, and the average allopathic (M.D.) medical school graduate has $162,000 in debt

DOES BURNOUT AFFECT MEDICAL CARE?

- Increasing burnout is a safety risk
- Annalena Welp*, Laurenz L. Meier and Tanja Manser"Emotional exhaustion and workload predict clinician-rated and objective patient safety", Frontiers in Psychology, January 2015, 1573 | 2
- Effects on empathy
  - Desensitization with increased exposure
  - No decrease in personal distress
- Correlation with increased work hours/ night shifts
  - Compassion fatigue

  Bellolio et al, W J Of Em Med Sep 2014; XV; 6
- Productivity decrease ?
- Effects on pain perception

  Gleichgerrcht, Decety, Frontiers in Behavioral Neuroscience, June 2014, 8;243


Acute stress disorders or PTSD
Depression
Burnout
Stress

BURNOUT VS STRESS

- Stress is often characterized by:
  - Over-engagement
  - Increased activity, anxiety
- Burnout has:
  - Loss of motivation, ideals, hope
  - Disengagement
  - Blunted emotions/ emotional exhaustion

BURNOUT VERSUS DEPRESSION

- Expanding field of study
- Health care providers (Physicians, Nurses) at all stages are at risk for depression
- Medical students and residents screen positive for depressive symptoms
  - Up to 55% of medical students report depressive sx, but don't necessarily carry a diagnosis of depression

    (Chang, Eden-Folsebee, Coverdale, Acad Psych 2012; 36(3):177-82)
- Depression as a risk factor for MI in male physicians

  Center C, Davis M, Detre T, et al. Confronting depression and suicide in physicians: a consensus statement. *JAMA*. Jun 18 2003;289(23):3161-6. [Medline].

DSM-V CRITERIA FOR MAJOR DEPRESSIVE DISORDER

- **Diagnostic Criteria**
- Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
  - **Note:** Do not include symptoms that are clearly attributable to another medical condition.
  - Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
  - Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
  - Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note:** In children, consider failure to make expected weight gain.)
  - Insomnia or hypersomnia nearly every day.
  - Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
  - Fatigue or loss of energy nearly every day.
  - Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

DSM-V CRITERIA FOR MAJOR DEPRESSIVE DISORDER

  - Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
  - Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The episode is not attributable to the physiological effects of a substance or to another medical condition.
- **Note:** Criteria A–C represent a major depressive episode.
- **Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.
- In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self-esteem is generally preserved, whereas in MDE feelings of worthlessness and self-loathing are common. If self-derogatory ideation is present in grief, it typically involves perceived failings vis-à-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.
- The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- There has never been a manic episode or a hypomanic episode.
  - **Note:** This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

SUICIDE IN PHYSICIANS

- Suicide is common in physician populations
  - 2-4%
- Higher rate of completion than the general population
- Higher rate of completion in females (equal M:F ratio)

Worley LL. Our fallen peers: a mandate for change. *Acad Psychiatry*. Jan-Feb 2008;32(1):8-12. [Medline].

Frank E, Dingle AD. Self-reported depression and suicide attempts among U.S. women physicians. *Am J Psychiatry*. Dec 1999;156(12):1887-94. [Medline].

ACUTE STRESS DISORDER, PTSD

- Occur in context of trauma exposure
- ~4% of first responders
- Linked to personal risk factors

DSM-IV DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER

- A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others (2) the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms: (1) a subjective sense of numbing, detachment, or absence of emotional responsiveness (2) a reduction in awareness of his or her surroundings (e.g., "being in a daze") (3) derealization (4) depersonalization (5) dissociative amnesia (i.e., inability to recall an important aspect of the trauma)
- C. The traumatic event is persistently reexperienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated. startle response, motor restlessness). F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or in:; the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling f..:. members about the traumatic experience.
- The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- F. The disturbance is not due to the direct physiological effects substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

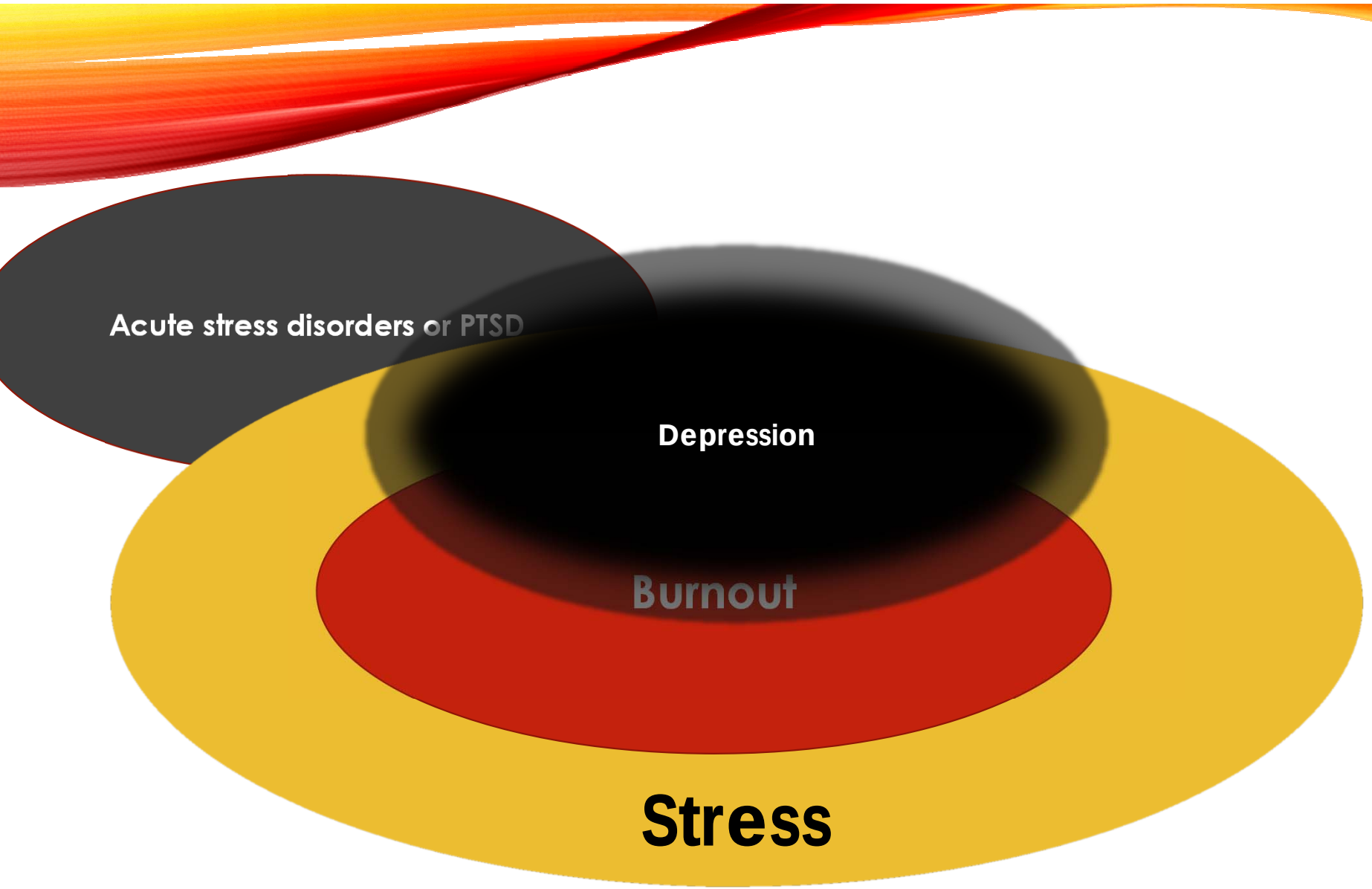
DSM-V DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER

- **Diagnostic Criteria308.3 (F43.0)**
- Exposure to actual or threatened death, serious injury, or sexual violation in one (or more) of the following ways:
  - Directly experiencing the traumatic event(s).
  - Witnessing, in person, the event(s) as it occurred to others.
  - Learning that the event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
  - Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).
    - **Note:** This does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.
- Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:
  - **Intrusion Symptoms**
    - Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). **Note:** In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
    - Recurrent distressing dreams in which the content and/or affect of the dream are related to the event(s). **Note:** In children, there may be frightening dreams without recognizable content.
    - Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) **Note:** In children, trauma-specific reenactment may occur in play.
    - Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
      - **Negative Mood**
    - Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
      - **Dissociative Symptoms**

DSM-V DIAGNOSTIC CRITERIA FOR ACUTE STRESS DISORDER

- An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
- Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
  - **Avoidance Symptoms**
- Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
  - **Arousal Symptoms**
- Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
- Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- Hypervigilance.
- Problems with concentration.
- Exaggerated startle response.

- Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
  - **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.


Acute stress disorders or PTSD
Depression
Burnout
Stress

MASLACH BURNOUT QUESTIONNAIRE

Fig. 1 Maslach Burnout Inventory—voluntary written self-assessment of stress and burnout assessing the three main components of the burnout syndrome—emotional exhaustion (EE), depersonalisation (DP) and personal achievement (PA)

How Often	0	1	2	3	4	5	6
	Never	A few times a year or less	Once a month or less	A few times a month	Once a week	A few times a week	Every day

Question	Statement	How Often (0-6)
1	I feel emotionally drained from my work.	
2	I feel used up at the end of the workday.	
3	I feel fatigued when I get up in the morning and have to face another day at work.	
4	I can easily understand how my patients feel about things.	
5	I feel I treat some patients as if they were impersonal objects.	
6	Working with people all day is a real strain for me.	
7	I deal very effectively with the problems of my patients.	
8	I feel burned out from my work.	
9	I feel I'm positively influencing other people's lives through my work.	
10	I've become more callous toward people since I took this job.	
11	I worry that this job is hardening me emotionally.	
12	I feel very energetic.	
13	I feel frustrated by my job.	
14	I feel I'm working too hard on my job.	
15	I don't really care what happens to some of my patients.	
16	Working with people directly puts too much stress on me.	
17	I can easily carte a relaxed atmosphere with my patients.	
18	I feel exhilarated after working closely with my patients.	
19	I have accomplished many worthwhile things in this job.	
20	I feel like I'm at the end of my rope.	
21	In my work, I deal with emotional problems very calmly.	
22	I feel patients blame me for some of their problems.	

“BURDEN OF DIFFICULT ENCOUNTERS MEASURE”

- Used to estimate a low, medium, or high frequency of difficult encounters in practice.
- How often do the following interactions occur? (1=never; 4=often)
- Patients who:
  - Visit regularly, but ignore medical advice
  - Have expectations for care that are unrealistic
  - Insist on being prescribed an unnecessary drug
  - Insist on an unnecessary test
  - Persistently complain, although you have done everything possible to help
  - Do not express appropriate respect
  - Show dissatisfaction with your care
  - Are verbally abusive

An,Baier Manwell, Williams et al *Does a higher frequency of difficult patient encounters lead to lower quality care?*
JOURNAL OF FAM PRAC JANUARY 2013;62,1

EMOTIONAL SIGNS OF BURNOUT

- Sense of failure and self-doubt
  - Loss of esteem, self-worth, and sense of control and mastery
- Feeling helpless, trapped, defeated
- Detachment
- Loss of motivation
- Increasingly cynical and negative outlook
- Decreased satisfaction and sense of accomplishment
- Burnout mediates Anxiety symptoms in individuals complaining of occupational stress (Ding et al, Plos one, 2014 September, 9;9)

BEHAVIORAL MANIFESTATIONS OF BURNOUT

- Needing substances (alcohol/drugs) to cope
- Less patience with co-workers
- Absenteeism
- Not meeting deadlines (change in functioning)
- Increased job turnover

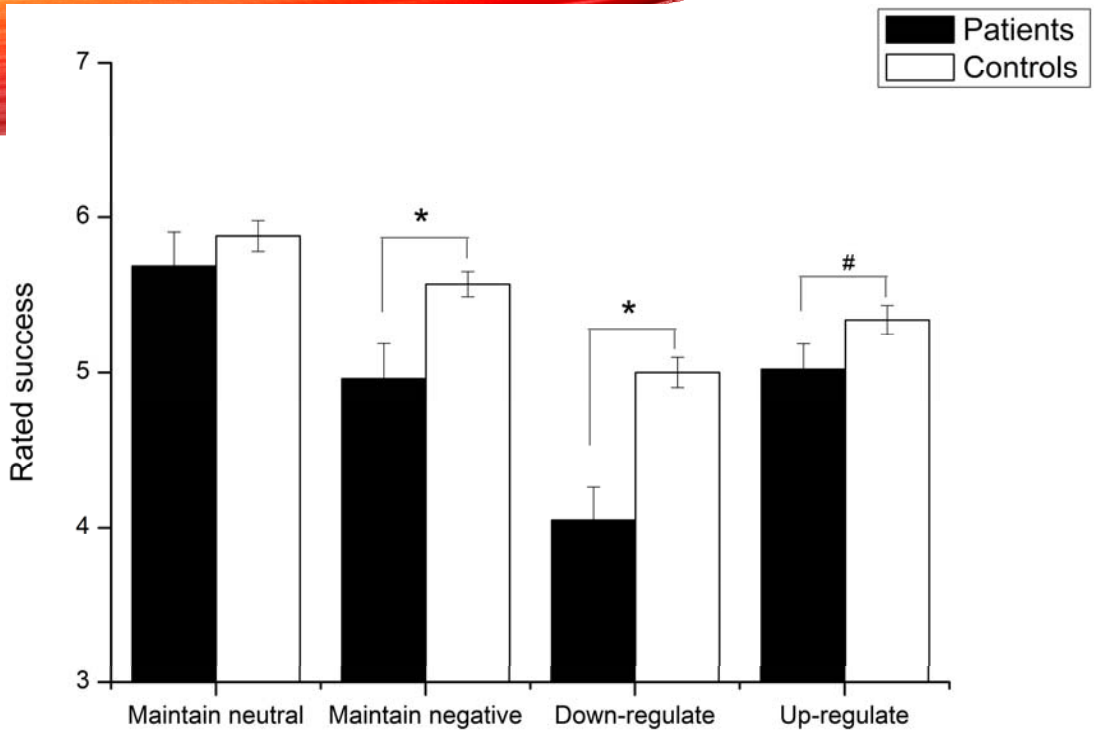
PHYSICAL SIGNS OF BURNOUT

- Increased somatic symptoms
- Fatigue
- Physiologically, burnout is an example of classic adaptation syndrome
  - compensation (0)
  - alarm (I) *increase heart rate variability and sympathetic tone*
  - resistance (II)
  - exhaustion (III)

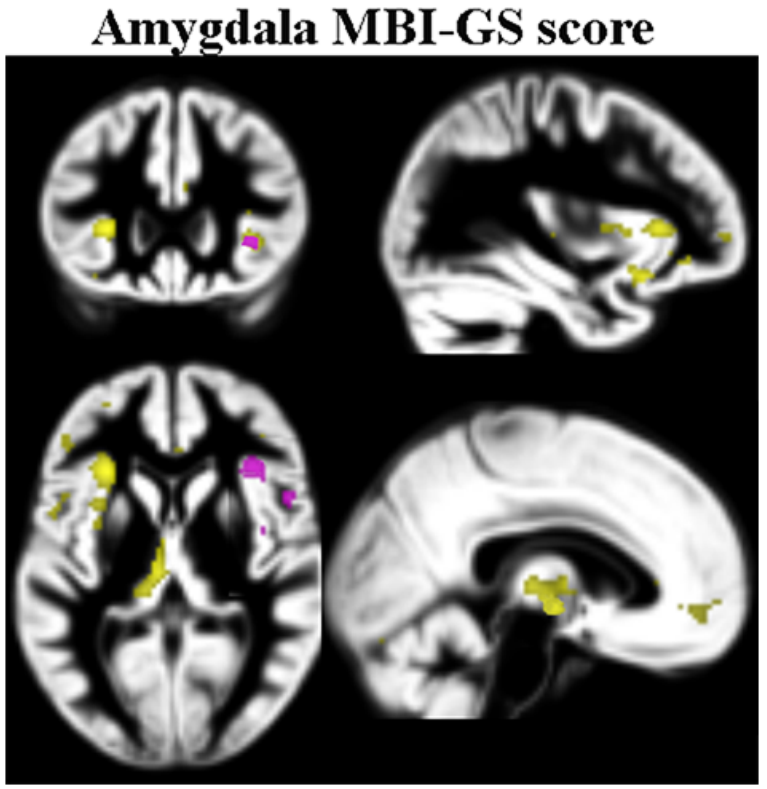
    Kotov, Revina, Bulletin of Experimental Biology and Medicine, Vol. 153, No. 5, September, 2012
- Weight fluctuations, difficulty losing weight

DOES BURNOUT AFFECT BRAIN CONNECTIVITY?

- Potential biological underpinnings of chronic occupational stress
- Impaired ability to modulate emotions
- Alerted connectivity between amygdala and mPFC
- Correlates with scores on Maslach inventory
- Different than pattern observed in depression
- Golkar et al, Plos one, Sep 2014;9;9
- Possible relation with hypocorticolism
  - * use of antidepressant common and confounding
  - Lennartsson et al "Burnout and hypocortisolism – a matter of severity? A study onACTH and cortisol responses to acute psychosocial stress", Frontiers in Psychiatry February 2015 | Volume 6 | Article 8 | 1



Comparison between burnout patients and controls regarding rated regulation success across task instructions.
The burnout group rated themselves as generally less successful at implementing the task instruction after viewing negative pictures. * = p<.05, # = p<.1.
doi:10.1371/journal.pone.0104550.g003



Yellow clusters denote significant interaction between the left amygdala connectivity map and the MBI-GS score merging both groups.
Pink clusters denote corresponding clusters from the right amygdala. Clusters calculated at p<0.05 FWE corrected, and superimposed on the grey matter template (in the MNI space) from the entire study group.
doi:10.1371/journal.pone.0104550.g005

RISK FACTORS FOR BURNOUT

- Personal:
  - Perfectionism
  - Lack of flexibility
  - Substance use and personal hx
  - Lack of collaboration
- Compassion fatigue:
  - Mediates de-personalization
- Gender effects
- Extent of practice

Gleichgerrcht E, Decety J (2013) Empathy in Clinical Practice: How Individual Dispositions, Gender, and Experience Moderate Empathic Concern, Burnout, and Emotional Distress in Physicians.

RISK FACTORS FOR BUNOUT

- Organizational:
  - Isolation
  - Uncertainty
  - Change
  - Increased demands
- PRACTICE-RELATED:
  - High-frequency, difficult cases
  - Not associated with worse quality of patient care or higher rates of error

An,Baier Manwell, Williams et al *Does a higher frequency of difficult patient encounters lead to lower quality care? JOURNAL OF FAM PRAC JANUARY 2013;62,1*

An, Rabatín, Manwell, et al. Burden of difficult patient encounters in primary' care: data from the Minimizing Error, Maximizing Outcome Study.,Arch Int Med.2009;169:410-414

SPECIALTY-SPECIFIC STRESSORS

- Increasing workload
- Feeling isolated
- Perceived lack of recognition
- Conflicting demands
- Evolving standards
- Last recourse for patients/families
- Pressure to have “answers”

RESILIENCE & HARDINESS

- Traits involved in resilience and inversely related to stress
- Control of the environment
- Commitment to self-fulfilling goals
- Reasonable levels of challenge in daily life

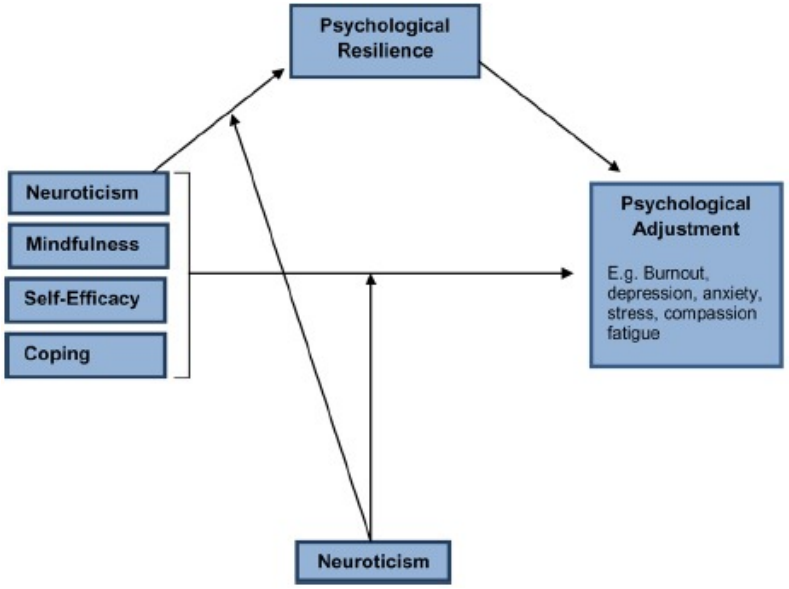
Thomsens SB, Arnetz P, Nolan I, et al. Individual and orga-nizational well-being in psychiatric nursing. / Adu Nursing. 199930:749-757

RESILIENCE

- Genetic factors
- Flexible intrapersonal factors
- Personality traits
  - Neuroticism , e.g. being “high-strung”
  - Mindfulness, being able to detach from a situation, de-center/not judge
  - Coping style
  - Self-efficacy

- Rees et al, “Understanding individual resilience in the workplace: the international collaboration of workforce resilience model” Frontiers in Psychology January 2015

RESILIENCE VERSUS BURNOUT



Rees et al, “Understanding individual resilience in the workplace: the international collaboration of workforce resilience model” Frontiers in Psychology January 2015

WHEN/HOW DOES BURNOUT START IN MEDICAL TRAINING?

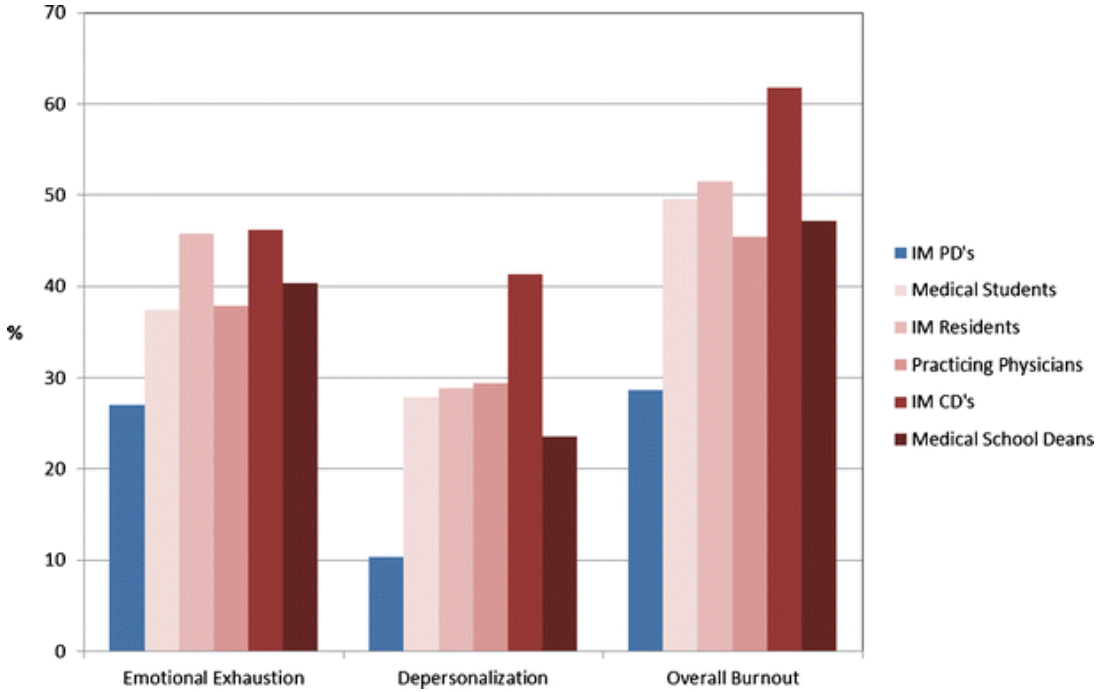
- Matriculating medical students have lower rates of burnout and depression than age-matched college graduates
- Matriculating medical students have higher quality of life scale scores

(Le Brazeau et al, Distress among Matriculating medical students relative to the general population, Acad Med 2014;89:00)

- By second/third year of medical school, up to half of medical students report burnout symptoms
  - Physical activity
  - Smoking/ex-smoking
  - Healthy food choices

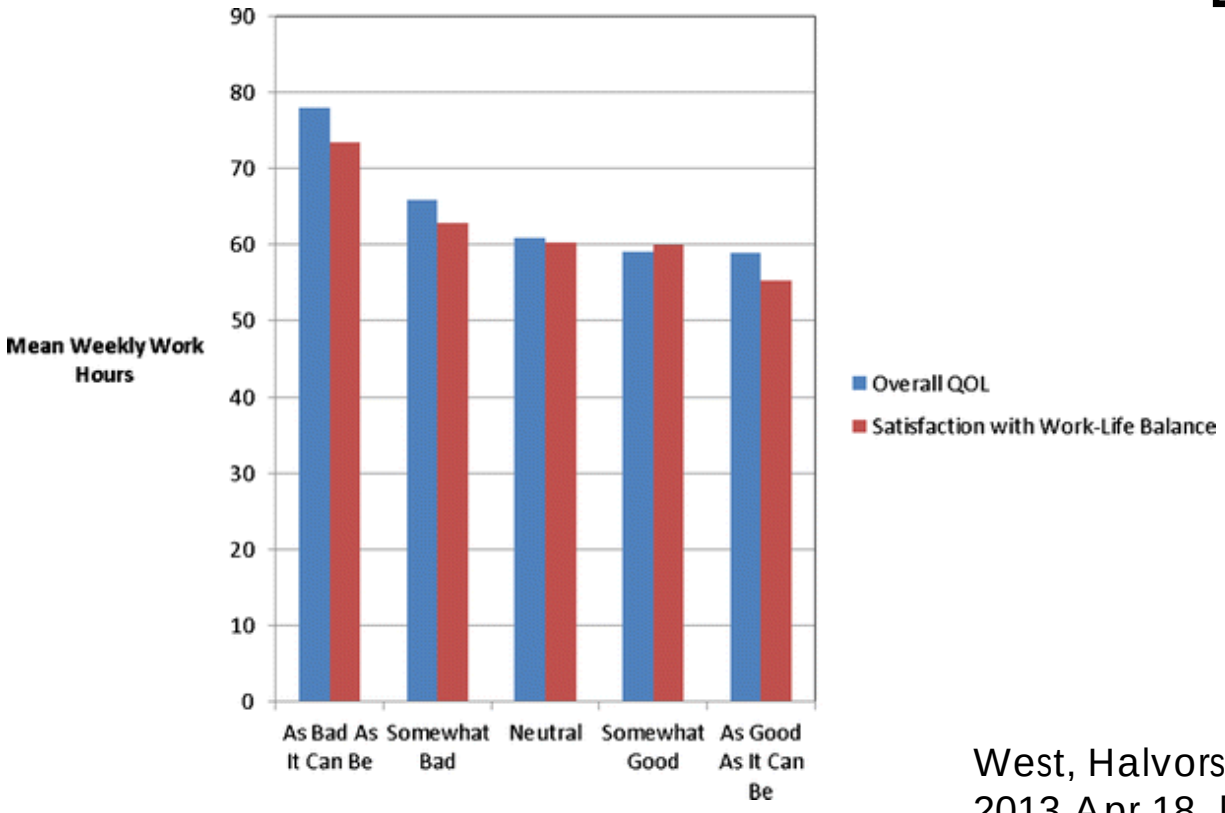
Cecil et al, Behaviour & Burnout in Medical students, Med Ed Online, 2014; 19:25209

BURNOUT IN VARIOUS HEATH CARE GROUPS



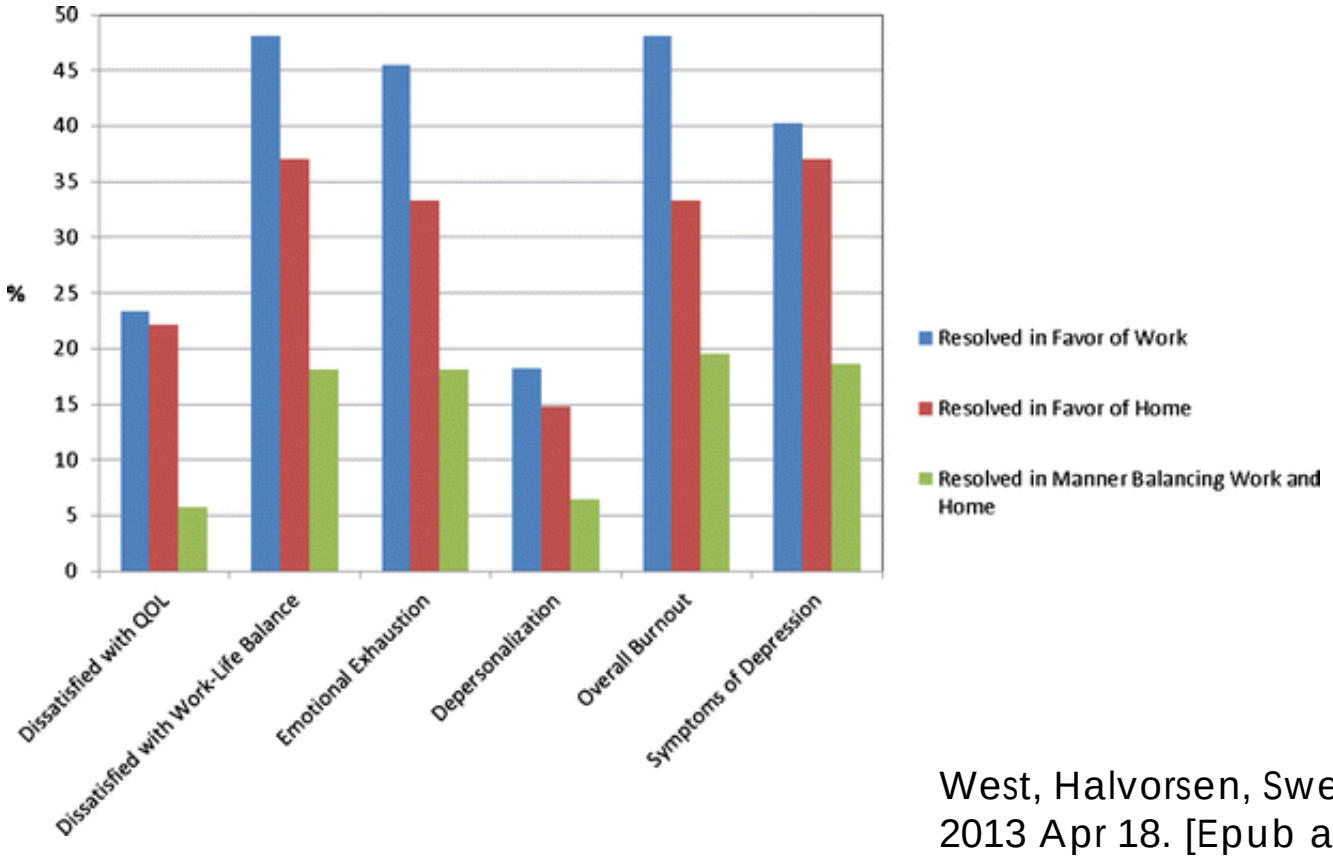
West, Halvorsen, Swenson,et al J Gen Intern Med. 2013 Apr 18. [Epub ahead of print]

BURNOUT AS A FUNCTION OF EXCESS WORK?



West, Halvorsen, Swenson,et al J Gen Intern Med. 2013 Apr 18. [Epub ahead of print]

BURNOUT AS A FUNCTION OF CONFLICT RESOLUTION



West, Halvorsen, Swenson,et al J Gen Intern Med. 2013 Apr 18. [Epub ahead of print]

GOALS

- **Recognize** – Watch for the warning signs of burnout
- **Reverse** – Undo damage by managing stress and seeking support
  - Exhaustion is the easiest to manage
- **Resilience** – Build resilience to stress by taking care of physical and emotional health

MAJOR IMPEDIMENTS TO TREATMENT IN PRACTITIONERS

- No specialized training for “a physician’s physician”, or a therapist’s therapist
- No formal mentorship
- Malpractice insurance issues
- Fear of loss of ability to practice
  - Fear of loss of respect
  - Confidentiality issues
- Self-treatment
- Guilt for having symptoms

WHAT ARE WE FIGHTING EXACTLY?

- Loss of the idealism or dream with which you entered your career
- Loss of the role or identity that originally came with your job
- Loss of physical and emotional energy
- Loss of friends, fun, and sense of community
- Loss of joy, meaning and purpose that make work – and life – worthwhile

SHORTER WORK HOURS?

- Since work hour restrictions in the US:
  - Less residents scored positive on depression screen
  - Less exhaustion
  - Less satisfaction
  - Less educational activity attendance

Gopal, Jasheen, Miyoshi et al,ARCH INTERN MED/VOL 165, DEC 12/26, 2005

- More burnout in senior physicians
  - European Working Time Directive

Richter, Kostova, Bauer et al Int Arch Occup Environ Health, Epub Feb 2013

A DIFFERENT STRUCTURE?

- Shorter clinical assignments?
- 2 vs 4 week inpatient coverage for attending physicians
  - Less burnout
  - Worse ratings on teasing, professionalism by house staff and students
  - Little effects on patient care and re-admission

Lucas, Trink, Evans et al,JAMA. 2012;308(21):2199-2207

VACATION USE?

- Estimate that US employees take 57% of vacation days
- Average 13 days per year
- For health care work, obstacles include
  - Need for coverage
  - Revenue issues
  - Pressure/expectations

PREVENTION/ INTERVENTIONS

Personal/group:

- Training in mindfulness
- Training in communication
- Stress management
  - Relaxation
  - Cognitive re-structuring
- Organizational:
  - Improved fit person/job
  - Duty hour limitations
  - Conversion to pass/fail grading systems

POTENTIAL SOLUTIONS

- Self-awareness, self-monitoring and self-regulation
- Mindfulness
- Meditation
- Support
- Focus on empathy
  - Avoiding compassion fatigue
- Specific solutions:
  - Pre-visit planning
  - Team involvement

- http://www.black-bile.com/
- http://www.mdmentor.com/
- www.afsp.org
- www.stressdoc.com
- www.apa.com

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Thanks for attending!

Questions?